

**TENNESSEE DEPARTMENT
OF
MENTAL HEALTH
AND
DEVELOPMENTAL DISABILITIES**

**MANAGED CARE STANDARDS
FOR
THE DELIVERY
OF
BEHAVIORAL HEALTH SERVICES**

Introduction

The Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) has developed the following manual to provide guidance related to TDMHDD's philosophy on the principles of Recovery and Resiliency, definitions of critical service components related to covered Medicaid services, and standards for providing behavioral health services to consumers. The guidelines outlined in this document are intended to clarify the expectations of any managed care contractor (MCC) and its network providers that provide behavioral health services in Tennessee. The definitions are provided to enhance MCCs' and their network provider's understanding of Medicaid covered services; however, nothing in this manual is intended to supersede or conflict with the MCCs' contractual obligations.

In addition to the standards outlined in this document, MCCs and their network providers must comply with all applicable state and federal laws and state rules and regulations including Title 33 Tennessee Code Annotated (<http://www.state.tn.us/mental/t33/compilation6-30-05.pdf>) and CFR 42 part 2. In some instances the standards in this manual may exceed those requirements. However, it is the expectation of TDMHDD that any time these standards exceed other requirements, entities are to comply with the most stringent standards.

Recovery and Resiliency

All behavioral health services shall be rendered in a manner that supports the recovery of persons experiencing mental illness and enhance the development of resiliency of children and families who are impacted by mental illness, serious emotional disturbance, and/or substance abuse issues. Recovery is a consumer driven process in which consumers are able to work, learn and participate fully in their communities. Recovery is the ability to live a fulfilling and productive life [with] a disability.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has released a consensus statement on mental health recovery. The components listed in this consensus statement are reflective of TDMHDD's desire that all behavioral health services be delivered in a manner that promotes individual recovery and builds resiliency.

The 10 Fundamental Components of Recovery include:

- **Self-Direction:** Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.

- **Individualized and Person-Centered:** There are multiple pathways to recovery based on an individual's unique strengths and resiliency as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.
- **Empowerment:** Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.
- **Holistic:** Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services (such as recreational services, libraries, museums, etc.), addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.
- **Non-Linear:** Recovery is not a step-by step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.
- **Strengths-Based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
- **Peer Support:** Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

- **Respect:** Community, systems, and societal acceptance and appreciation of consumers—including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.
- **Responsibility:** Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.
- **Hope:** Recovery provides the essential and motivating message of a better future—that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process.

Resiliency is a dynamic developmental process for children and youth that encompasses positive adaptation and is manifested by traits of self-efficacy, high self-esteem, maintenance of hope and optimism within the context of significant adversity.

Services that are provided to children and youth with serious emotional disturbances and their families should be delivered based on the System of Care Values and Principles that are endorsed by SAMHSA and CMHS (<http://www.state.tn.us/mental/mhs/soc1.html>) as listed below:

- Have access to a comprehensive array of services that addresses the child's physical, emotional, social and educational needs
- Receive individualized services in accordance with their unique needs and potential and guided by an individualized service plan
- Receive services within the least restrictive, most normative environment that is clinically appropriate
- Receive services that are integrated, with linkages between child servicing agencies and programs and mechanisms for planning, developing and coordinating services
- Receive case management or similar mechanisms to ensure that multiple services are delivered in a coordinated manner and adapted in accordance with the changing needs of the child and family
- Receive services without regard to race, religion, national origin, sex, physical disability or other characteristics

DEFINITIONS

The following definitions of recovery trainings and programs are meant to provide definitions of critical service components related to covered Medicaid services and guidance regarding the use of these terms within the TennCare program.

Psychiatric Rehabilitation

Psychiatric rehabilitation is an applied rehabilitation philosophy that offers persons with mental illness hope of recovery and return to meaningful activities of life. Psychiatric rehabilitation emphasizes competence and self-determination by building on strengths and by thoroughly assessing the support and skill demands of specific environments.

Psychiatric rehabilitation is an array of consumer-centered recovery services designed to support the individual in the attainment of his/her optimal level of functioning. These services are designed to capitalize on personal strengths, develop coping skills and strategies to deal with deficits and develop a supportive environment in which to function as independently as possible on the individual's recovery journey. These recovery oriented services include Supported Housing, Supported Employment, Peer Support, Illness Management and Recovery, and Psychosocial Rehabilitation.

Psychiatric rehabilitation promotes recovery, full community integration, and improved quality of life for persons who have been diagnosed with any mental health condition that seriously impairs their ability to lead meaningful lives. Psychiatric rehabilitation services are collaborative, person directed and individualized. Through these services, a person is assisted in determining their readiness to make changes, set rehabilitation goals, choose preferred environments, identify and establish needed supports, and develop necessary skills. These services are an essential element of the health care and human services spectrum and focus on helping individuals to develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning, and social environments of their choice.

Psychiatric rehabilitation includes services that:

- Provide a knowledge base for consumers to assist them in making sound treatment and rehabilitation choices. Examples of such services include peer support, WRAP and illness management, and recovery oriented classes.
- Develop skills that assist a consumer in getting and maintaining a job or living in the housing of their choosing. Supported employment and supported housing are an example of this kind of service.

- Develop life goals and the skills needed to attain these goals by working collaboratively with mental health professionals in a supported environment. Psychosocial rehabilitation is an example of such a service.

Peer Support Specialist

A Certified Peer Support Specialist is a person who has identified himself or herself as having received or is receiving mental health or co-occurring disorder services in his or her personal recovery process and has undergone training recognized by the Office of Consumer Affairs on how to assist peers with the recovery process. The Certified Peer Support Specialist will promote self-determination, personal responsibility and empowerment inherent in self-directed recovery; and assist others who are diagnosed with mental illness or co-occurring disorders to achieve control over their own recovery process.

Under the general supervision of a mental health professional, a Certified Peer Support Specialist may perform a wide range of direct peer-to-peer support services. Each Certified Peer Support Specialist has the ability, but is not limited to, developing community support; assisting in the development of rehabilitation goals; serving as an advocate, life coach, mentor, or facilitator for resolution of issues a peer is unable to resolve on his or her own; or providing education on the importance of maintaining personal wellness and recovery.

This certification does not imply the Certified Peer Support Specialist is qualified to diagnose an illness, prescribe or provide clinical services. The Certified Peer Support Specialist Program is not an offer of employment or job placement by the Tennessee Department of Mental Health and Developmental Disabilities. This certification in no way guarantees employment. Each Certified Peer Support Specialist should apply for positions available in his or her community.

The following table delineates the specific responsibilities of the Certified Peer Support Specialist, case manager, and mental health professional in regards to each aspect of mental health care. The table is not meant to be exhaustive but is meant instead to provide general guidance for the differences in job responsibilities between these various job roles:

	Peer Specialist	Case Manager	MH Professional	Employment/ Housing/ Psychosocial Staff
Planning Service	Assist consumer in developing recovery plan/WRAP	Assist consumer in developing a service plan	Develop treatment plan with consumer	Assist consumer in developing employment/housing plan
Resource Service	Teach/role model/coach how to utilize resources and navigate the MH system	Referral & Linkage	Clinical assessment	Identify resources needed to implement plan
Illness Management Service	Teach/support/coach the acquisition and exercise of skills needed for management of symptoms	Ensure consumer has access/continuity of care throughout the MH and primary health care system	Clinical education and training regarding symptomatology and medication management	Assist consumers so that illness/symptoms does not negatively impact employment and housing goals
Medication Management Service	Teach/model/coach importance of monitoring symptoms and/or medication reactions, effective communication with doctors/therapists	Ensure consumer has resources to acquire medication, has transportation for appointments and consumer attendance to appointments	Clinical treatment to include individual and group therapy	Educate employers/landlords on the treatment process and role of medication and symptoms in the management of the illness, as appropriate
Employment/Housing Service	Teach/model/coach skills/attributes needed to attain and maintain employment and housing	Ensure consumer has access to psychosocial rehab, supportive employment, and housing options	Clinical consultation and assessment	Employment and housing support by facilitating opportunities for housing and job placement
Education Service	Teach consumers through BRIDGES/imr curriculum understanding/skills needed to manage illness	Encourage consumer to utilize community/natural supports to assist in illness management	Provide clinical support through individual therapy sessions	Teach skills needed to maintain housing and employment

BRIDGES

Building Recovery & Individual Dreams & Goals through Education and Support (BRIDGES) was founded in 1995. BRIDGES is a self-help program that provides education and support to mental health consumers. There are two parts to the program: 1) a 10 week education component that offers detailed information on mental illness, treatment, self-help skills, and the philosophy of recovery. The goal of the classes is to empower students to take an active role in their treatment and recovery. Classes include discussions and exercises to help students apply the information 2) support groups facilitated by mental health consumers. The support group meetings provide a structured way for individuals to work with one another to strengthen coping skills and deal with the realities of living with a mental illness. These meetings supply the emotional glue that enables people to ease individual and group feelings of helplessness, hopelessness, and guilt.

- **Copyright and Licensing Agreement-** NAMI TN has the copyright for the BRIDGES curriculum and has a licensing agreement with the Tennessee Mental Health Consumers Association (TMHCA) that allows TMHCA to administer and manage the program.
- **Training Requirements-** BRIDGES is taught by consumers who have been trained to teach the curriculum by TMHCA. Only persons trained by TMHCA are allowed to teach BRIDGES. The curriculum teacher training is a three day training and the support group facilitator training is a two day training.
- **Certification-** Certification is given by TMHCA to those who pass two oral presentations for the three-day curriculum training and one oral presentation for the two-day support group facilitator training.

Peer Counseling

Peer counseling is the use of active listening and problem solving skills to help peers. Peer counseling is based upon the concept that people are capable of solving most of their own problems of daily living. Peer counseling sessions are structured therefore so that the consumer generates solutions that they are more likely to act upon.

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Characteristics-

- Listening actively and empathetically
 - Providing problem solving expertise
 - Creating a safe and supportive environment
 - Encouraging the consumer to clarify the issues or problem
 - Helping the consumer brainstorm and explore options
 - Supplying information
 - Letting the consumer come up with their own solutions
 - Aiding the consumer to develop decision-making skills
 - Advocating on the consumer's behalf
 - Supporting the consumer to follow through on their own decisions
- **Training-** TMHCA offers training in peer counseling. The training consists of 15 hours of class work. The curriculum covers the following areas:
 - History of peer counseling and support
 - Defining the job and ethics of peer counseling
 - Developing relationship skills
 - Developing active listening skills
 - Integrating active listening and relationship skills
 - Practicing problem solving including stopping aggressive behavior, preventing suicide, and helping in a crisis

Tests are conducted after each of the above areas is covered in the classroom.

- **Certification-** TMHCA offers certification to all individuals who pass the tests that are given during the 15 hour training.

Wellness Recovery Action Plan

The Wellness Recovery Action Plan (WRAP) is a self-management and recovery system developed by Mary Ellen Copeland. A symptom monitoring and response system, WRAP emphasizes wellness tools and strategies, including medication management, getting quality health care, and developing a wellness lifestyle to manage mental illness. Based on its proven positive outcomes, WRAP was designated as an exemplary program by SAMHSA.

- **Training-** WRAP consists of two parts. In WRAP I, consumers not only learn how to develop a personalized WRAP but also learn the five key concepts of recovery (hope, personal responsibility, education, self-advocacy, and support), which empower and motivate consumers to feel the way they want to feel, make their lives the way they want them to be, and move toward rediscovering and meeting their goals. In WRAP I, consumers learn that the WRAP is a symptom monitoring and response system that emphasizes wellness tools and strategies, including medication management, getting quality health care, stress reduction techniques, healthy diet, physical exercise, changing negative thoughts to positive, and developing a wellness lifestyle to manage mental illness.

WRAP I helps consumers discover how their strengths can enhance their recovery.

Successful completion of WRAP I and using a personally created WRAP are prerequisites for WRAP II (Facilitators' Training). Facilitators must know from their own experience how to use WRAP to be credible instructors. In the Facilitators' Training, participants learn the values and ethics of WRAP, to lead classes, the language of recovery, how to handle certain situations and answer questions, facilitation skills, ways to develop presentations, and the full curriculum is reviewed. In order to graduate WRAP II with the facilitator's certification, a participant must demonstrate the ability to introduce and lead a workshop, agree to adhere to the ethics of WRAP, and be able to share the five key concepts and seven parts of WRAP.

- **Certification-** The test for WRAP I is the completion of a personal WRAP. To receive certification for WRAP II, participants must demonstrate the ability to lead a workshop, agree to adhere to the ethics of WRAP, and be able to share the five key concepts and seven parts of WRAP.

Only an Advanced Level Trainer can conduct a WRAP II course. The prerequisites for certification of Advanced Level Training is completion of WRAP I and II, being a trainer for a minimum of one year, the teaching of a minimum of three WRAP classes, and completion of a five day Advance Level Trainer which is only offered through the Copeland Center.

Evidence Based Practice (EBP) Illness Management and Recovery

EBP Illness Management and Recovery (IMR) is a SAMHSA evidence based practice. EBP IMR is a series of weekly sessions in which a specially trained mental health practitioner assists a consumer to develop his or her own personal strategies for coping with mental illness and moving forward in his or her life. The program can be provided in an individual or group format, and generally lasts between 3 to 6 months. The following subjects are covered in educational handouts: 1) recovery strategies, 2) practical facts about mental illness, 3) the stress vulnerability model and treatment strategies, 4) building social support, 5) reducing relapses, 6) using medication effectively, 7) coping with stress, 8) coping with problems and symptoms, and 9) getting your needs met in the mental health system.

An EBP IMR program is one that is in accord with the fidelity measures found in the SAMHSA toolkit. The fidelity measures include the following:

- 1) EBP IMR is taught individually or in groups of 8 or less
- 2) Consumers receive at least 3 months of weekly EBP IMR sessions
- 3) Curriculum materials for each of the 9 subject areas found above are available for EBP IMR practitioners to use in their sessions
- 4) All consumers participating in EBP IMR receive EBP IMR handouts
- 5) The involvement of the consumer's significant other in the EBP IMR process
- 6) Practitioners help consumers identify realistic and measurable recovery goals
- 7) Practitioners and consumers collaboratively follow-up on the recovery goals identified in number 6
- 8) Practitioners regularly use motivation-based strategies
- 9) Practitioners embrace the concept of and regularly apply educational techniques
- 10) Practitioners regularly use cognitive-based techniques to teach IMR information and skills
- 11) Practitioners embrace the concept of and systematically provide coping skills training, relapse training, and behavioral tailoring for medication.

- **Training-** The SAMHSA toolkit on EBP IMR does not specifically require a training protocol.

Illness Management and Recovery

Illness management and recovery (imr) is any program that assists consumers in developing personal strategies for coping with mental illness and moving forward in their recovery process. In order for such imr programs to be considered for Medicaid reimbursement, the program must be approved by TDMHDD. The CRA does not specify that imr be rendered as the SAMHSA EBP IMR. Therefore, imr is not limited to one curriculum such as the EBP IMR. Instead, it is open to all evidence-based and/or best practice classes/programs such as WRAP, BRIDGES, and the Eli Lilly Partners for Excellence in Psychiatry (PEP) Neuroscience Treatment Team Partner (NTTP) program.

PEP: NTTP

Partners for Excellence in Psychiatry (PEP) Neuroscience Treatment Team Partner (NTTP) program is a pre-packaged, modular, recovery based illness management and wellness psychosocial program that was developed by a group of renowned experts and supported by Eli Lilly and Company. The program consists of effective stage-based motivational, cognitive and behavioral strategies and interventions tailored to mediate the cognitive impairments associated with mental illness. There is evidence supporting this program as a best practice to promote recovery and wellness.

NTTP consists of two parts:

- **Team Solutions** offers materials for the teams on how they can educate consumers about mental illness, treatment options, and living skills.
- **Solutions for Wellness** offers materials for teams on how they can educate consumers on nutrition, wellness, and living a healthy lifestyle. The intent of the training is to bridge the gap between mental health and physical health care.

Unlike EBP IMR, there are no strict guidelines or fidelity scales on how agency teams need to implement NTTP. Agencies are free to use the NTTP materials and training as they see fit within their agencies.

- **Training process-** NTTP is a two day training that is offered to teams of three to eight staff members of an agency. These teams consist of a staff person representing the administration, the medical staff, and the agency where the program will be implemented. Direct care staff from the program are also encouraged to attend. Certificates of Attendance are offered to persons who complete the training.

Recovery Innovation's Peer Employment Training (Taught by a META Certified Facilitator)

Agencies such as Peninsula (Knoxville, TN) and Centerstone (Nashville, TN) offer this two week, intensive, 80 hour training that is competency based with in-class discussions, role play, homework, 10 take home tests, and a final exam. It builds personal recovery and interpersonal skills plus professional skills that are useful in any work environment. However, it is especially designed to promote peer recovery. The 80 hour training includes recovery principles, the power of peer support, self-esteem and self-talk, cultural diversity, emotional intelligence, telling your own story, employment as a path to recovery, ethics and boundaries, communication skills, conflict resolution, dealing with anger, understanding trauma and resilience, substance abuse, being with people in challenging situations, and partnering with professionals. This program prepares graduates to work with peers in a variety of paid or volunteer mental health related positions, not limited to peer specialists.

- **Certification process-** Class participants must pass 10 take home tests that are given to participants during the 80 hour training. They must also pass a final exam that is given at the end of the training.

Psychosocial Rehabilitation

Program focus is based on a strengths model of mental health, working with the whole service recipient to improve service recipient functioning, rather than treatment for symptoms of a mental illness. Service participants, in partnership with staff, form goals for skill development in the areas of vocational, educational, and interpersonal growth that serve to maximize opportunities for successful community integration. Service participants proceed with goal development at their own pace and may continue in the program with varying intensity for an indefinite period of time.

An individual who works in a psychosocial or any other psychiatric rehabilitation setting can enhance their professional status by becoming a Certified Psychiatric Rehabilitation Practitioner (CPRP) by the US Psychiatric Rehabilitation Association (formerly known as the International Association of Psychosocial Rehabilitation Services (IASPRS)). The CPRP is a test-based certification program.

The clubhouse model of psychosocial programs is a variation on the psychosocial model. The AIM Center (Chattanooga, TN) is an example of a clubhouse model. In a clubhouse model, members work side by side to manage all the operations of the clubhouse, providing an opportunity for members to contribute in significant and meaningful ways. The International Center for Clubhouse Development (ICCD) has developed a set of standards by which centers can assess the quality of their program. Centers wishing to officially adopt the clubhouse model can request a visit from ICCD who will assess adherence to ICCD standards.

Supported Employment

Supported employment (SE) consists of a range of services to assist individuals to choose, prepare for, obtain, and maintain gainful employment that is based on individual's preferences, strengths, and experiences. This service also includes a variety of support services to the individual, including side-by-side support on the job. These services may be integrated into a psychosocial center.

The SAMHSA Toolkit on Supported Employment states that SE is based upon six principles:

1. Eligibility is based on consumer choice;
2. Supported employment is integrated with treatment
3. Competitive employment is the goal
4. Job search starts soon after a consumer expresses interest in working
5. Follow-along supports are continuous
6. Consumer preferences are important.

The SAMHSA Toolkit on Supported Employment lists the following fidelity measures as critical to be considered as an evidence based practice:

1. Employment specialists manage caseloads of up to 25 clients
2. Employment specialists provide only vocational services
3. Each employment specialist carries out all phases of vocational service
4. Supported employment services are integrated with mental health treatment
5. Employment specialists function as a unit rather than a group of practitioners
6. There are no eligibility criteria to receive the service
7. Vocational assessment is an ongoing process
8. The search for competitive jobs occurs rapidly after program entry
9. Employer contacts are based on clients job preferences
10. Employment specialists provide job options that are in different settings
11. Employment specialists provide competitive job options that have permanent status rather than temporary status
12. All jobs are viewed as positive experiences on the path of vocational growth and development
13. Individualized follow-along supports are provided to employer and client on a time-limited basis.
14. Vocational services are provided in natural community settings.

Supported Housing

Within the TennCare program, supported housing refers to facilities staffed twenty four hours per day, seven days a week with associated mental health staff supports for individuals that require treatment services and supports in a highly structured setting. These facilities are for persons with serious and/or persistent mental illness and are not residential treatment facilities. Supported housing is intended to prepare individuals for more independent living in the community while providing an environment that allows individuals to live in community settings with appropriate mental health supports. Given this goal, every effort should be made to place individuals near their families and other support systems and original areas of residence. Supported housing does not include the payment of room and board.

Specialized Training

Managed care contractors' network providers that render behavioral health services shall provide specialized training in accordance with the following standards:

- A. The MCCs must establish a written plan that ensures their contract providers receive the training components as listed in the chart below.
- B. In order to improve upon the skills of staff members delivering behavioral health services, providers must provide the following training components:

Training Topic	Staff to receive	Time Frame to be provided
<p>Evidence-based practices identified and recognized by the SAMHSA Center for Mental Health Services (CMHS) that include:</p> <ul style="list-style-type: none"> • Illness management and recovery skills; • Supported employment; • Family psychoeducation; • Assertive Community Treatment (ACT); • Integrated dual disorders treatment (substance use and mental illness); <p>Resources:</p> <p>http://www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits</p>	<p>All staff members (this does not include administrative staff who do not directly render behavioral health services to consumers)</p>	<ul style="list-style-type: none"> • Initially within the first 90 days of employment • Every 3 years thereafter

Training Topic	Staff to receive	Time Frame to be provided
Psychopharmacology	All staff members (this does not include administrative staff who do not directly render behavioral health services to consumers)	<ul style="list-style-type: none"> Initially within the first 90 days of employment Every 3 years thereafter
Prevention and intervention techniques used by staff to maintain a safe environment	All staff members, including administrative staff	<ul style="list-style-type: none"> Initially within the first 90 days of employment Annually thereafter
TDMHDD designated crisis services curriculum	Crisis services staff and Certified Peer Support Specialist, as applicable.	<ul style="list-style-type: none"> Initially within the first 90 days of employment Every 3 years thereafter
<p>System of Care values and principles for the treatment of children and youth that are child centered and family focused, community based, culturally competent and evaluated for effectiveness and wraparound supports tailored to fit the individual child and family unit</p> <p>Resource:</p> <ul style="list-style-type: none"> http://www.state.tn.us/mental/mhs/soc1.html 	Children and youth staff members	<ul style="list-style-type: none"> Initially within the first 90 days of employment Every 3 years thereafter
Legal issues and mandates regarding mental illness, serious emotional disturbance and substance abuse including but not limited to forensics, mandatory outpatient treatment, confidentiality, and involuntary commitment	All staff members (this does not include administrative staff who do not directly render behavioral health services to consumers)	<ul style="list-style-type: none"> Initially within the first 90 days of employment Every 3 years thereafter

Training Topic	Staff to receive	Time Frame to be provided
Cultural competence. This includes recognizing any unique aspects of members. These may include language, dress, traditions, notions of modesty, eye contact, health values, help-seeking behaviors, work ethics, spiritual values, attitudes regarding treatment of mental illness and substance abuse, concepts of status, and issues of privacy and personal boundaries. Linguistic competency reflects the ability to communicate in a manner understandable to the person served	All staff members, including administrative staff	<ul style="list-style-type: none"> Initially within the first 90 days of employment Every 3 years thereafter
Etiology, treatment, and diagnostic categories of mental illness; serious emotional disturbance; substance abuse; physical and sexual abuse; suicidal ideation; developmental disabilities; and mental retardation*	All staff members (this does not include administrative staff who do not directly render behavioral health services to consumers)	<ul style="list-style-type: none"> Initially within the first 90 days of employment
Mental health case management principles, assessment for treatment planning, intervention techniques, philosophy, and facilitating access to community resources*	Case management staff members and Certified Peer Support Specialists	<ul style="list-style-type: none"> Initially within the first 90 days of employment
General health care practices and medical conditions that may be associated with mental illness, serious emotional disturbance and substance abuse	All staff members (this does not include administrative staff who do not directly render behavioral health services to consumers)	<ul style="list-style-type: none"> Initially within the first 90 days of employment

Training Topic	Staff to receive	Time Frame to be provided
Recovery and resiliency-based approaches to providing services and the development of treatment planning and goal setting for individuals in need of behavioral health services*	All staff members (this does not include administrative staff who do not directly render behavioral health services to consumers)	<ul style="list-style-type: none"> Initially within the first 90 days of employment Every three years thereafter
Principles of Psychiatric Rehabilitation to include: psychosocial rehabilitation, supported housing, supported employment, peer support, and illness management and recovery	Psychiatric Rehabilitation staff members and Certified Peer Support Specialists	<ul style="list-style-type: none"> Initially within the first 90 days of employment Every 3 years thereafter
Age appropriate developmental principles and Early Periodic Screening, Diagnosis and Treatment (EPSDT) requirements for children and youth	Children and youth staff members	<ul style="list-style-type: none"> Initially within the first 90 days of employment
CPR and first aid	At least one staff member with current certification available at all provider locations at all times during operating hours	<ul style="list-style-type: none"> Certification must be maintained in accordance with the certifying entity
Consumer rights and responsibilities, consumer advocacy and alternative decision making such as custody, educational rights, declarations for mental health treatment, durable power of attorney, guardianship and conservatorships	All staff members, including administrative staff	<ul style="list-style-type: none"> Initially within the first 90 days of employment Every three years thereafter

Training Topic	Staff to receive	Time Frame to be provided
TDMHDD Best Practice Guidelines- Adult behavioral health services and Behavioral health services for children and youth Resource: <ul style="list-style-type: none"> • http://www.state.tn.us/mental/omd/omdbpg.html 	All staff members (this does not include administrative staff who do not directly render behavioral health services to consumers)	<ul style="list-style-type: none"> • Initially within the first 90 days of employment • Every three years thereafter
Non-discrimination	All staff members, including administrative staff	<ul style="list-style-type: none"> • Initially within the first 90 days of employment • Annually thereafter

*Training should be appropriate to the population served.

- C. Documentation of training and results of post-tests to evidence staff members' comprehension are maintained by the agency with which the individuals are employed.
- D. Application of knowledge gained through the training should be tied to the assessment of staff competency during re-credentialing and performance evaluations.
- E. Staff members currently employed with a provider have one year after the effective date of a provider's contract with an MCC to receive any trainings listed above that they have not already successfully completed.

Rights and Responsibilities

Managed care contractors and their contract providers shall demonstrate a commitment to treating consumers in a manner that acknowledges their rights and informs them of their responsibilities while receiving care. These rights and responsibilities shall be distributed to each consumer at the time of enrollment into an MCC as well as during intake at any of their network provider agencies. At the provider agencies, documentation must be obtained that these rights and responsibilities were provided to and explained to the consumers in a manner that is sensitive to their culture, language, and level of functioning. The MCC shall be responsible for providing interpreter and translation services free of charge to any member who needs such services, including but not limited to members with Limited English Proficiency and members who are hearing impaired.

In addition to distribution of these rights and responsibilities to consumers upon enrollment, the MCC shall maintain a written policy that recognizes and ensures the rights and responsibilities of consumers.

Consumers have the right:

1. to be treated with consideration, respect, and full recognition of their dignity and individuality regardless of their state of mind or condition;
2. to be provided treatment without regard to age, race, sex, religion, ethnic background, handicap, or ability to pay;
3. to privacy and confidentiality related to all aspects of care including, but not limited to, the unwarranted disclosure of medical records, in whole or in part;
4. to be protected from neglect; to be protected from physical, emotional, or verbal abuse, and from all manner of exploitation;
5. to be free from any form of isolation, restraint or seclusion used as means of coercion, discipline, convenience, or retaliation;
6. to be informed of any proposed treatment and/or alternative treatment methods;
7. to be informed of the risks, benefits, consequences of treatment or nontreatment;
8. to be informed of the side effects of his/her medication or proposed medication;
9. to participate in the development of his/her individual treatment plan;
10. to participate in all decision-making regarding his/her behavioral health care, including discharge or aftercare planning;
11. to be provided quality treatment by competent staff members;
12. to be afforded continuity of care from one service provider to another;
13. to refuse to participate partially or fully in treatment or therapeutic activities (unless participation is so ordered by the court);
14. to be provided treatment in the least restrictive setting that is clinically appropriate, feasible, and available;

15. to refuse the use of any audio and/or visual techniques to record or observe the individual's activities during treatment unless written and signed consent is given;
16. to participate fully or to refuse to participate in community activities including cultural, educational, religious, community service, vocational, and/ or recreational activities;
17. to be provided with information about the MCC, its services, and its providers;
18. to be provided with the basic rights and responsibilities of MCC consumers in a way which is easily understood;
19. to be able to choose providers within the limits of the network and to be able to refuse care from specific providers;
20. to voice complaints or initiate appeals about the MCC or services provided without fear of restraint, interference, coercion, discrimination, or reprisal;
21. to be informed about and to formulate advance directives, such as a Declaration for Mental Health Treatment, or to designate a person to make decisions using a durable power of attorney for health care;
22. to have access to his or her own medical records and request that they be amended or corrected;
23. to make recommendations to the MCC regarding the consumers' rights and responsibilities policies; and
24. to be provided with a listing of available advocacy services and contact information when requested.

Consumers have the responsibility:

1. to provide, to the extent possible, information needed by staff members rendering services to the consumer;
2. to follow the instructions and guidelines given by providers, and
3. to participate, to the degree possible, in understanding their behavioral health problems and develop mutually agreed upon treatment goals.

Consumer Records and Treatment Planning

Records may be on paper or electronic. The MCC and its contract providers shall promote the maintenance of consumer records in a legible, current, detailed, organized, and comprehensive manner. Consumer records shall meet the following standards and contain the following elements, if applicable, to permit effective service provision and quality reviews:

1. Information related to the provision of appropriate services to a consumer must be included in his/her record to include documentation in a prominent place whether there is an executed Declaration for Mental Health Treatment.
2. For individuals in the priority population, a comprehensive assessment that provides a description of the consumer's physical and mental health status at the time of admission to services. This comprehensive assessment covers:
 - a. a psychiatric assessment which includes: description of the presenting problem, psychiatric history and history of consumer's response to crisis situations, psychiatric symptoms, multi-axial diagnosis using the most current edition of Diagnostic and Statistical Manual of Mental Disorders (DSM), mental status exam, and history of alcohol and drug abuse;
 - b. a medical assessment that includes: screening for medical problems, medical history, present medications, and medication history;
 - c. A substance use assessment that includes frequently used over-the-counter medications, alcohol and other drugs and history of prior alcohol and drug treatment episodes. The history should reflect impact of substance use in the domains of the community functioning assessment.
 - d. Target Population Group (TPG) and Clinically Related Group (CRG) assessments performed by persons certified by TDMHDD;
 - e. A community functioning assessment or an assessment of the consumer's functioning in the following domains: living arrangements, daily activities (vocational/educational), social support, financial, leisure/ recreational, physical health, and emotional/behavioral health; and

- f. An assessment of consumer strengths, current life status, personal goals, and needs.
- 3. An individualized treatment plan, which is based on the psychiatric, medical, substance use, and community functioning assessments listed above, must be completed for any consumer who receives behavioral health services for thirty (30) calendar days or longer.
 - a. The treatment plan must be completed within the first thirty (30) days of admission to behavioral health services and updated every six (6) months, or more frequently as necessary based on the consumer's progress towards goals or a significant change in psychiatric symptoms, medical condition, and/or community functioning.
 - b. Documentation that the consumer and, as appropriate, his/her family members or legal guardian, participated in the development and subsequent reviews of the treatment plan.
 - c. For providers of multiple services, one comprehensive treatment plan is acceptable as long as at least one goal is written, and updated as appropriate, for each of the different services that are being provided to the consumer.
 - d. The treatment plan must contain the following elements:
 - i. Identified problem(s) for which the consumer is seeking treatment;
 - ii. Consumer goals related to problem(s) identified;
 - iii. Measurable objectives to address the goals identified;
 - iv. Target dates for completion of objectives;
 - v. Responsible parties for each objective;
 - vi. Specific measurable action steps to accomplish each objective;
 - vii. Individualized steps for prevention and/or resolution of crisis, which includes, but is not limited to, identification of crisis triggers (situations, signs, and increased symptoms); active steps or self-help methods to prevent, de-escalate, or defuse crisis situations; names and phone numbers of contacts that can assist consumer in resolving crisis; and the consumer's preferred treatment

options, to include psychopharmacology, in the event of a mental health crisis.

4. Progress notes are written to document status related to goals and objectives indicated on the treatment plans.
5. Correspondence concerning the consumer's treatment and signed and dated notations of telephone calls concerning the consumer's treatment.
6. A brief discharge summary must be completed within fifteen (15) calendar days following discharge from services or death.
7. Discharge summaries for psychiatric hospital and residential treatment facility admissions that occur while the consumer is receiving behavioral health services.
8. The author signs all entries in records with credentials and date noted.
9. There is a record review process to assess the content of the consumer records for legibility, organization, completion, and conformance to standards listed above.

CRISIS SERVICES

Definition

Behavioral health crisis services shall be rendered when there is a perception of a crisis by an individual, family member, law enforcement, hospital staff or others. Crisis services are available to anyone in Tennessee regardless of insurance type or coverage and are available twenty-four (24) hours a day, seven (7) days a week. Crisis services include twenty-four (24) hour toll free telephone lines answered in real time by trained crisis specialists and face-to-face crisis services including, but not limited to: prevention, triage, intervention, evaluation/referral for additional services/treatment, and follow-up services. Peer support specialists shall be utilized in conjunction with crisis specialists to assist adults in alleviating and stabilizing crises and promote the recovery process. Behavioral health crisis service providers are not responsible for pre-authorizing emergency involuntary hospitalizations.

Behavioral health crisis services shall operate as the single portal of entry for emergency involuntary psychiatric inpatient services for TennCare enrollees. Prior to admission to psychiatric hospitalization on an involuntary basis, each TennCare and uninsured individual must be evaluated. This evaluation must be completed by a behavioral health crisis services provider which may include a

Mandatory Pre-screening Agent (MPA). A MPA must evaluate all proposed admissions to a State-operated Regional Mental Health Institute (RMHI). A behavioral health crisis can be either an **emergency** or **urgent** in nature. A **behavioral health emergency** is defined as an acute onset of a behavioral health condition that manifests itself by an immediate substantial likelihood of serious harm by one or more of the following:

- Threatened or attempted suicide or serious bodily harm;
- Threatened or attempted homicide or violent behavior;
- Placed others in reasonable fear of violent behavior and serious physical harm; and/or
- The person is unable to avoid severe impairment or injury from specific risks.

An **urgent condition** is defined as an acute onset of a behavioral health related condition, not constituting an immediate substantial likelihood of harm, but if left untreated; the condition may deteriorate into a **behavioral health emergency** or cause the individual unnecessary anxiety. Behavioral health crisis service providers shall utilize the following service components to ensure a continuum of crisis services.

SERVICE COMPONENTS

Activating Behavioral Health Crisis Services

Telephone and Walk-in Triage

Behavioral health crisis services can be activated by telephone contact or at a walk-in center. A triage screening determines the acuity of the crisis situation and determines the appropriate intervention needed to alleviate and/or stabilize the crisis. The triage screening can be completed via telephone assessment or, in the case of a walk-in service, via a face-to-face assessment. The triage screening also helps to determine the individual's current status such as:

- If there is a behavioral health provider treating the individual;
- The existence/availability of a support system;
- The existence/availability of a treatment plan; and
- If a face-to-face crisis assessment or other services are needed.

Crisis Services Intervention

An intervention may be completed via telephone or face-to-face. At the time of intervention, an assessment is completed to determine the need(s) of the individual including but not limited to the need for active, supportive listening or need for referrals to additional services and/or treatment. It will also be determined if there is an immediate substantial likelihood of serious harm (see definition of **behavioral health emergency** above). The intervention is intended to involve the appropriate resources, to include identifying the availability and obtaining a treatment or crisis/wellness plan when possible. All appropriate

resources should be utilized in an effort to stabilize the individual and prevent escalation of the crisis.

Telephone Intervention

A telephone intervention occurs between crisis staff and the individual and/or the family/health care providers, as appropriate. The intervention is intended to assess the need(s) of the individual for possible face-to-face contact with crisis services or a referral to the appropriate resource(s) in order to support and/or stabilize the individual and prevent escalation of the crisis.

Face-to-face Crisis Intervention

Crisis staff completes a face-to-face assessment when the triage screening or telephone intervention deems it appropriate due to the nature of the crisis situation. The assessment required for completion during crisis service interventions shall include standardized elements prescribed by TDMHDD. The standardized evaluation process shall be followed to ensure consistency and quality of the delivery of behavioral health crisis services. The face-to-face assessment determines the need(s) of the individual, referral(s) to additional services/treatment, and/or intervention to support and/or stabilize the individual and prevent escalation of the crisis. Face-to-face assessments may also be needed to evaluate the risk of immediate substantial likelihood of harm (see definition of **behavioral health emergency** above). Face-to-face crisis interventions can be conducted for walk-ins or a crisis specialist can be dispatched to the location of the individual to determine the need for services.

Mandatory Pre-Screening Agent (MPA)

Tennessee law requires a face-to-face evaluation, known as pre-screening, of each individual in crisis to assess eligibility for emergency involuntary admission to a RMHI and to determine whether all available, less drastic, alternative services and supports are unsuitable to meet the individual's needs. A MPA is required to complete one (1) of the certificates of need (CONs) prior to an emergency admission to a RMHI. Private hospitals that have been approved by TDMHDD and accept the authority of a MPA may also accept CONs from a MPA for emergency involuntary admissions.

Behavioral Health Crisis Respite

All behavioral health crisis service providers must provide access to crisis respite twenty-four hours a day, seven days a week (24/7) for all individuals meeting guidelines for this level of treatment, including but not limited to:

- The individual has a diagnosed or suspected mental illness;
- Mental status exam reveals no immediate intent to harm self or others;
- Respite is deemed a safe level of treatment;
- Respite would be an appropriate and beneficial level of treatment; and

- A brief time of rest and support is considered appropriate to stabilize or alleviate the crisis situation.

Behavioral health crisis respite services are intended to provide immediate shelter to those individuals with emotional/behavioral problems who are in need of emergency respite. These services involve short-term respite with overnight capacity for room and board, while meeting the individual's crisis need(s). Trained crisis respite staff members typically provide crisis respite. However, others who are deemed appropriate by crisis staff members may render respite services. For children/youth, authorization must be given for the use of crisis respite services by the parent, legal guardian, legal custodian, legal caretaker, or court with appropriate jurisdiction.

If a behavioral health crisis respite service provider is unable to obtain a current treatment plan, then the behavioral health crisis respite service provider shall complete a respite plan that is developed and agreed upon in writing by the individual, respite staff, and family/care givers/support system as applicable. The plan should include actions to attain stabilization or alleviation of the crisis situation. Crisis respite must be rendered in a community location approved by the managed care company or a site licensed by TDMHDD that can be facility-based, home-based or hospital-based in nature, depending on the need and availability.

Facility-based Crisis Respite Services

Crisis respite services that utilize a placement in a facility with direct care from trained crisis respite staff in direct response to a consumer's acuity level based on the assessment of risk.

Home-based Crisis Respite Services

Crisis respite services that utilize a placement in a home approved by the behavioral health crisis services provider with direct care from trained crisis respite staff or family members/significant others in direct response to a consumer's acuity level based on the assessment of risk.

Hospital-based Crisis Respite Services

Crisis respite services that utilize hospital emergency rooms or other acute psychiatric services based on the assessment of risk to the individual and/or the need for a medically supervised setting.

Crisis Stabilization Services

Crisis stabilization services are short-term supervised care services, accessed to prevent further increase in symptoms of a behavioral health illness or to prevent acute hospitalization. Crisis stabilization services are more intensive than regular crisis respite services in that they require more secure environments, highly trained staff, and have typically longer stays. Crisis stabilization services should include availability and utilization of the following types of services on a short-term basis as appropriate:

- Individual and/or family counseling/support;
- Medication management/administration;
- Stress management counseling;
- Individualized treatment plan development that empowers the consumer;
- Mental illness/substance abuse awareness/education; and
- Identification and development of natural support systems.

If a crisis stabilization service provider is not able to obtain a current treatment plan, then the crisis stabilization services provider shall complete a crisis stabilization plan that is developed and agreed upon in writing by the individual, staff, and the individual's significant others, if appropriate. This plan identifies services and assistance needed to achieve stabilization as well as the components needed for discharge or transition to a lower level of care. Discharge/transition plans are to address what criteria are needed for the individual to move safely to a less restrictive level of care. This plan may also detail what is needed to move an individual to a higher level of care if it is deemed appropriate.

Follow-Up Services

Follow-up services can be telephone call(s) or face-to-face assessment(s) between crisis staff and the individual, following crisis intervention, respite, or stabilization to ensure the safety of the individual until treatment is scheduled or treatment begins and/or the crisis is alleviated and/or stabilized. Follow-up services can include crisis services staff contacting the individual only one time or can include several contacts a day for several days, as deemed appropriate by crisis staff.

A follow-up contact with the individual must be made within twelve (12) hours of a MPA face-to-face assessment. A follow-up contact with the individual must be made within twenty-four (24) hours of a crisis specialist face-to-face assessment that does not involve a MPA.

